MEDI-CAL FOR FAMILIES

Electronic Funds Transfer Form

1. Applicant information

First Name:	**Last Name:**
Family Member Number:	**Monthly Premium Amount:**

2. Bank information

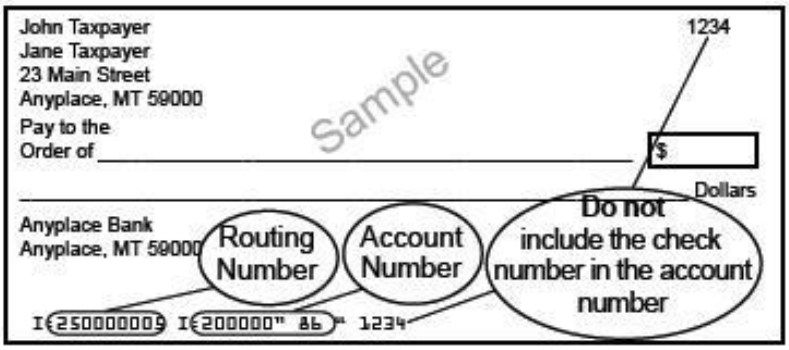
Bank Account Holder's First Name:	**Bank Account Holder's Last Name:**
Name of Bank:	**Address of Bank Branch:**
City:	**State, Zip Code:**

Account type: (Please check one)

____ Checking Bank Transit Routing number | | | | | | | | | |

____ Savings Account number | | | | | | | | | | | | | | | | |

See Sample for Routing & Account Numbers →



3. Signature

I give permission to Medi-Cal For Families Program to begin withdrawing funds each month out of the account described above, in the amount of the monthly premium.

_____ _____

Signature of Bank Account Holder Date

_____

Printed Name of Bank Account Holder

NOTE: This permission to withdraw funds will remain in effect until Medi-Cal For Families receives written notice from the applicant to discontinue the monthly electronic funds transfer (EFT). In order to allow enough time to process your EFT form, **you will need to pay your premiums in another way until the EFT starts. The EFT will start approximately 6 to 8 weeks after you sign up.** If the applicant becomes no longer eligible for Medi-Cal For Families, the EFT will end.

Please complete this entire form. Enclose a blank check or savings deposit slip and write the word "VOID" on it.

Mail to: Medi-Cal For Families – Premium Payment Section
PO Box 138011 Sacramento, CA 95813-8011

Questions? Call 1- 800-880-5305 Monday to Friday, 8 a.m. to 8 p.m., or Saturday, 8 a.m. to 5 p.m. The call is free.